This presentation was provided as a Webinar for Health Home Care Coordinators which aired on December 12, 2013. Review of this PowerPoint presentation satisfies, in part, the required State-sponsored special training modules for Health Home Care Coordinators.

This is part one of two Webinars on this topic.

This PowerPoint provides is an overview of Long Term Services and Supports and many of you know some or most of this information especially if you have worked in an Area Agency on Aging (AAA) as a case manager. However some Care Coordinators may not be as familiar with core DSHS social programs that are available through home and community based services now referred to as long term services and supports.

This presentation is intended to ensure that those who have no or limited experience working with DSHS and its subcontractors become knowledgeable about the service options that exist within core long term programs offered by DSHS.

Information within this presentation may be helpful if you work within an AAA and are wearing two hats as a case manager and Care Coordinator. It may help clarify the roles and may help you explain your role and interface with others in your organization who are providing core services and case management.

Learning Objectives

- Provide an overview of current delivery system under the Medicaid program
- Describe how care coordinators interface with case managers
- Review the Katz ADL Screening Tool and discuss its relationship to eligibility to LTSS
- Provide an overview of Medicaid Long Term Services and Supports (LTSS)

Medicaid in Washington State

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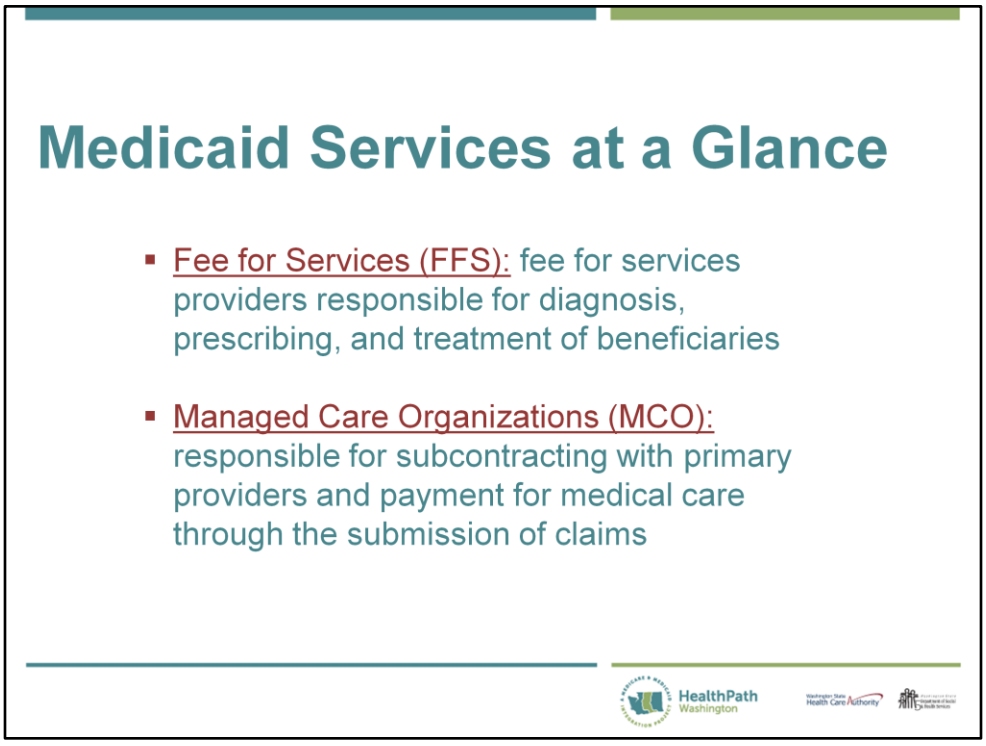
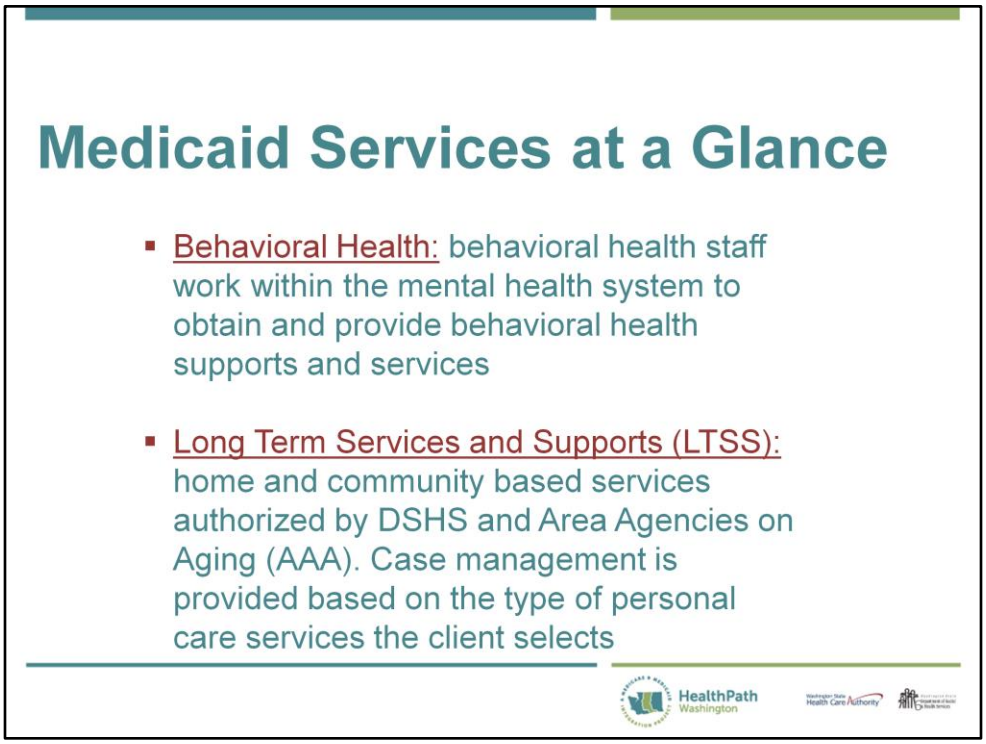
Overview of the Current Service Delivery System



In brief, the Medicaid program provides funding for four general types of services.



Of note is that nearly one in three Washingtonians receives some type of service through DSHS. This includes SNAP or the food stamp program. With the expansion of Medicaid in Washington State it is expected that half of a million residents will be added to the Medicaid Program.

The remainder of this presentation will focus on Medicaid long term services and supports.

Case resource managers complete CARE assessments and refer individuals to appropriate DDA services, other department services, and community programs and resources based on their assessed needs.

CARE is the acronym for the Comprehensive Assessment Reporting Evaluation. The CARE assessment is an electronic database that stores data from individual client assessments. CARE assessments are completed by Home and Community Services (HCS), DDA, Children's, and Area Agency on Aging staff. The CARE tool captures demographic information, client preferences, collateral contacts, diagnoses, medications, hearing and vision limitations, and decision-making capacity. Embedded in the software are screening tools such as the PHQ-9 (Personal Health Questionnaire 9, a screening tool for depression), and the Mini Mental Status Exam which assesses cognitive impairment. In addition the CARE tools records moods and behaviors, activities of daily living, and instrumental activities of daily living which will be discussed later in this presentation.

Case management is provided to clients residing in nursing facilities by Home and Community Services and the AAA. Case managers at Home and Community Services assist with discharges out of hospitals and the state's behavioral health hospitals.

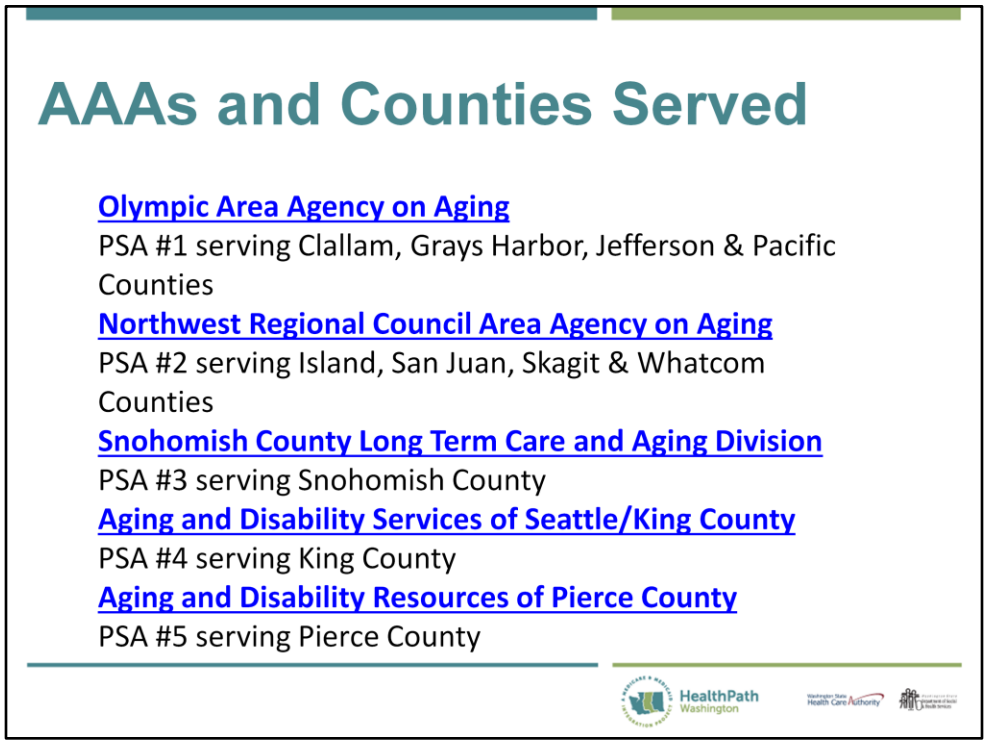
Residential settings are some times referred to as boarding homes or retirement centers and include: adult family homes, assisted living facilities, adult residential care facilities, and enhanced adult residential care facilities.

Case managers are assigned to all residential settings and provide reassessments, service planning, and payment authorizations.

Case managers are also assigned to nursing facilities. They provide case management while clients are in the nursing facility and may have access to special funds which are available only because the client was hospitalized or admitted to a nursing facility.

Case managers provide services to clients living in their own homes. Case management also includes assisting clients to transition in to other settings such as nursing facilities and other residential settings.

Other case management services provided by AAAs in addition to LTSS are non- core and targeted case management. Targeted case management may be provided to clients who have had an Adult Protective Services investigation or are at risk for abuse, neglect, or exploitation. These clients may also live in an environment that jeopardizes their personal safety or who are unable to supervise their paid caregiver. Non-core case management may be available to clients who do not qualify for core services but may be receiving services through other AAA services such as the Respite Program, nutrition programs, and other local services.



Some of the funding for Area Agencies on Aging comes from the Older American's Act. In Washington State there are 13 Planning and Services Areas also known as PSAs. They are listed on this and the following two slides and include the coverage areas by county.

AAAs and Counties Served

Lewis/Mason/Thurston Area Agency on Aging
PSA #6 serving Lewis, Mason and Thurston Counties

Southwest Washington Agency on Aging and Disabilities
PSA #7 serving Clark, Cowlitz, Klickitat, Skamania & Wahkiakum Counties

Aging & Adult Care of Central Washington
PSA #8 serving Adams, Chelan, Douglas, Grant, Lincoln & Okanogan Counties

Southeast Washington Aging and Long Term Care
PSA #9 serving Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Walla Walla & Yakima Counties

AAAs and Counties Served

Yakama Nation Area Agency on Aging
PSA #10 serving the Yakama Nation
Aging & Long Term Care of Eastern Washington
PSA #11 serving Ferry, Pend Oreille, Spokane, Stevens & Whitman Counties
Colville Indian Area Agency on Aging
PSA #12 serving the Colville Nation
Kitsap County Division of Aging & Long Term Care
PSA #13 serving Kitsap County

Before their 18th birthday clients may receive personal care services through the Medicaid Personal Care Program which is similar to the MPC program provided to adults. At age 18 their personal care services may be transferred to the aging and adult network if the child remains eligible and still requires the services.

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Referral, Intake, and Assessment

Accessing Services

- Children's Administration
  - Contact local office
- Developmental Disabilities Administration
  - Contact local office
- Home and Community Services
  - Contact local office
- Area Agencies on Aging
  - Contact local office
  - Aging and Disability Resource Centers

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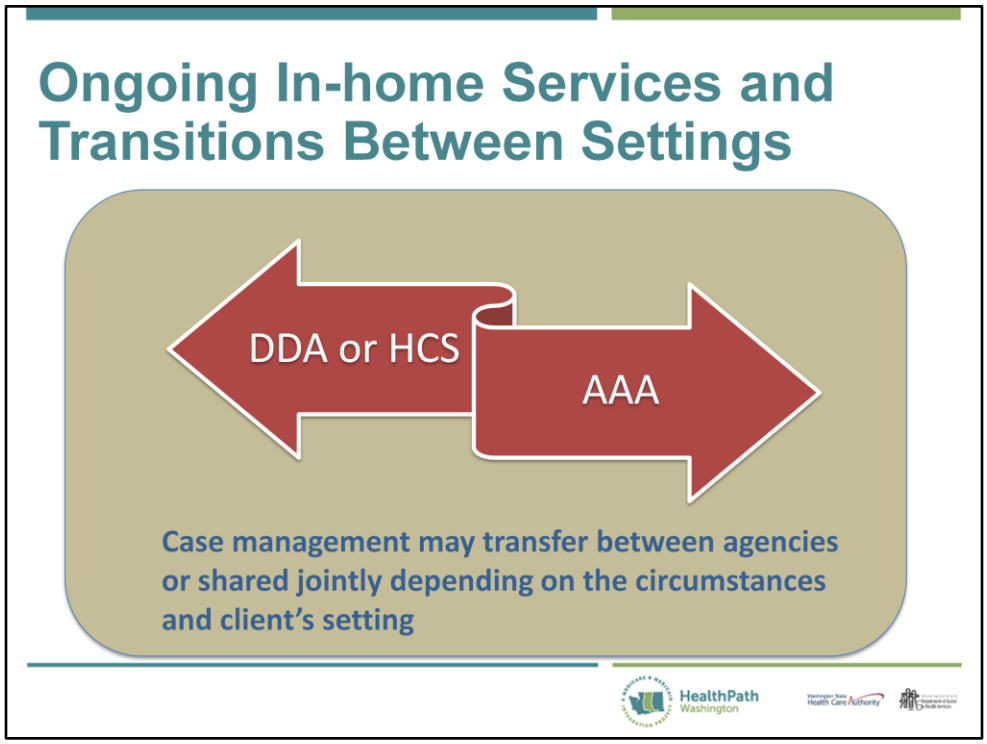
Information on how to make a referral can be found by calling the local office and speaking with intake staff. The Internet is an easy way to locate local offices and phone numbers. Links to these services will be provided at the end of this presentation.

The Area Agencies on Aging may also provide information through their senior information and assistance programs which are also known as Aging and Disability Resource Centers (ADRC) or Community Living Connections (CLC) programs.



Home and Community Services is the front door for core programs (MPC and COPES) for adults. MPC is the Medical Personal Care Program. COPES stands for the Community Options Program Entry System.

DDA is the front door for clients with developmental disabilities wishing to access the MPC program. DDA does not offer the COPES Program but does provide services under other Home and Community Based Services waivers. These programs also provide personal care and other LTSS. These services will be covered in the Part 2 presentation on Long Term Services and Supports.

DDA and HCS may share cases, some services remain with DDA while personal care services are authorized by HCS.

HCS, DDA, and the AAA may provide joint case management. This may occur as clients transition between settings such as their own home or a group home to hospitals or nursing facilities. The CARE program has the capability to allow case managers to share cases within the CARE system.

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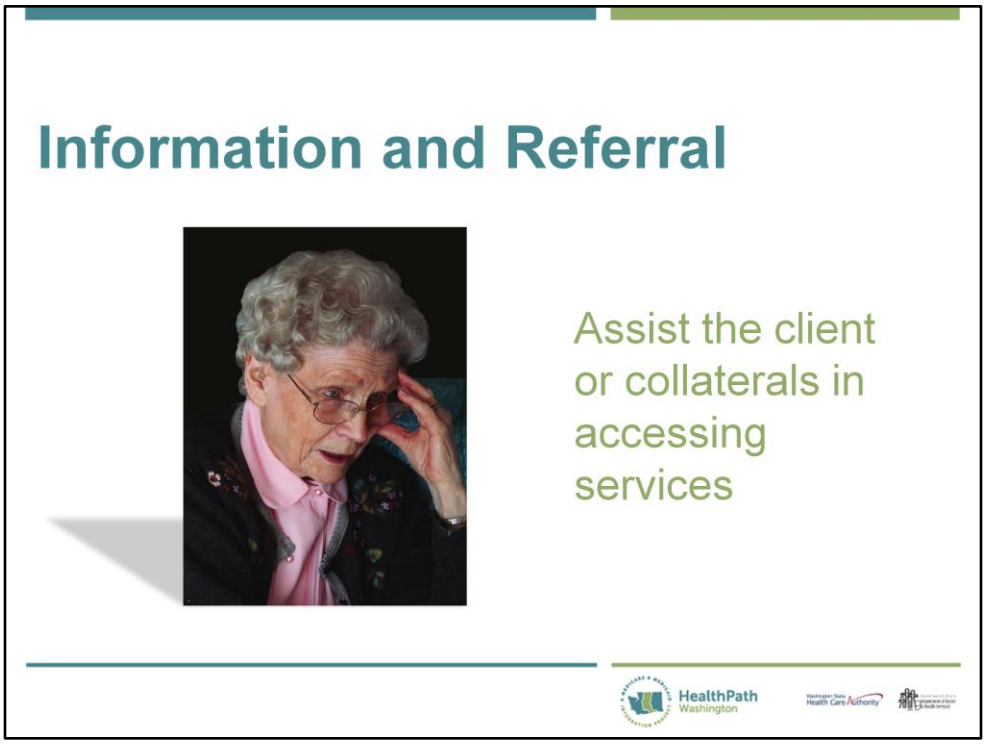
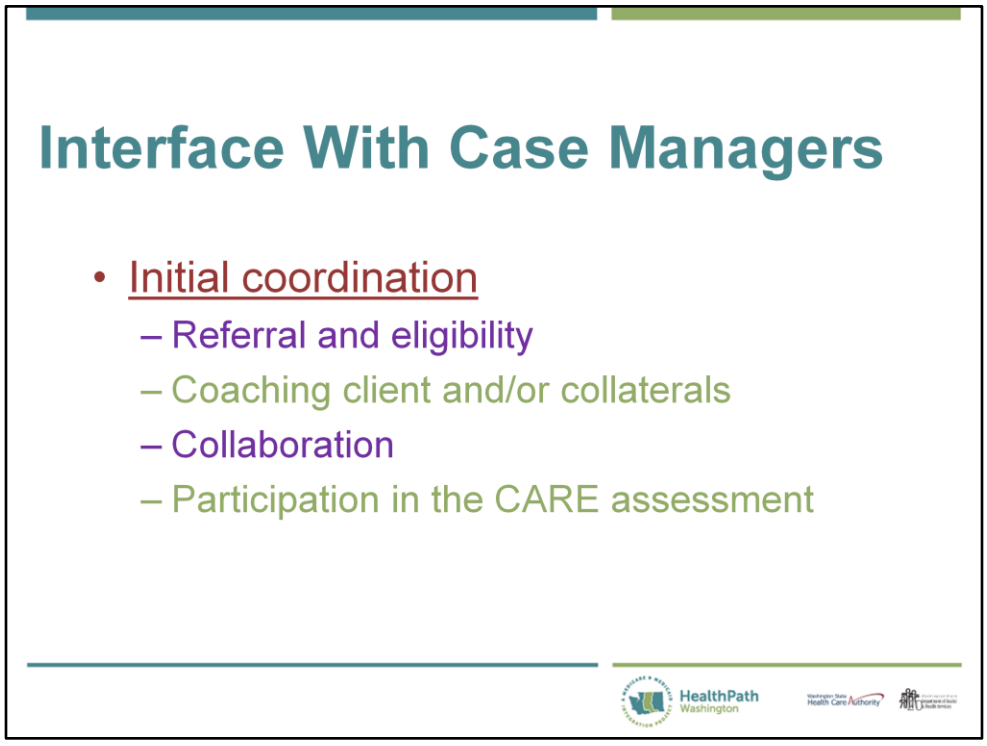
Role of the Care Coordinator

Your client may not be prepared to engage in LTSS however by developing or reviewing the Health Action Plan you may identify an opportunity to educate the client about core programs and provide coaching if they want to pursue these services.

Working with the HAP can also provide an opportunity for educating and coaching not only your client but collaterals such as family members and legal representatives.



If the client is agreeable to pursuing services the Care Coordinator may provide education and coaching on how to access services. One of the six functions the grant supports includes working with family members and collaterals. Involving collaterals could include education and coaching on how to navigate the long term services and supports system.



In your role as a Care Coordinator you may be required to collaborate with the financial services worker in addition to the case manager. You may be instrumental on some level working with clients or collaterals to ensure that client's respond to any requests from the financial service specialist regarding the Medicaid eligibility.

Support could include working with the client or family to complete eligibility reviews for ongoing Medicaid coverage.

A "significant change" may not warrant another CARE assessment. When working with case managers be prepared to describe how a new diagnosis or change in condition impacts functional ability. You may need to describe in detail what has changed with the client's diagnoses and therapies and how these change impact their functional capabilities.

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Overview of Core Programs

The MPC program provides personal care to individuals. These clients may be receiving SSI or are approved for other CN medical programs such as TANF and SSI-related medical. Services are available in the client's own home, adult family homes, or assisted living facility now known as ALFs. Clients served by Developmental Disabilities can access this program through their case resource managers and may receive these services in their own home or group homes.

Medicaid Personal Care Services

Eligibility is based on Activities of Daily Living (ADLs)

- Personal hygiene
- Dressing
- Transfers
- Eating
- Bathing
- Toilet use
- Locomotion and walking
- Medication management

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Eligibility is based on the client's functional needs. The CARE assessment screens the client for these ADL needs as reported by the client or their representative.

Medicaid Personal Care Services

Instrumental Activities of Daily Living (IADLs) are also assessed

- Housework
- Laundry
- Shopping
- Transportation to medical services

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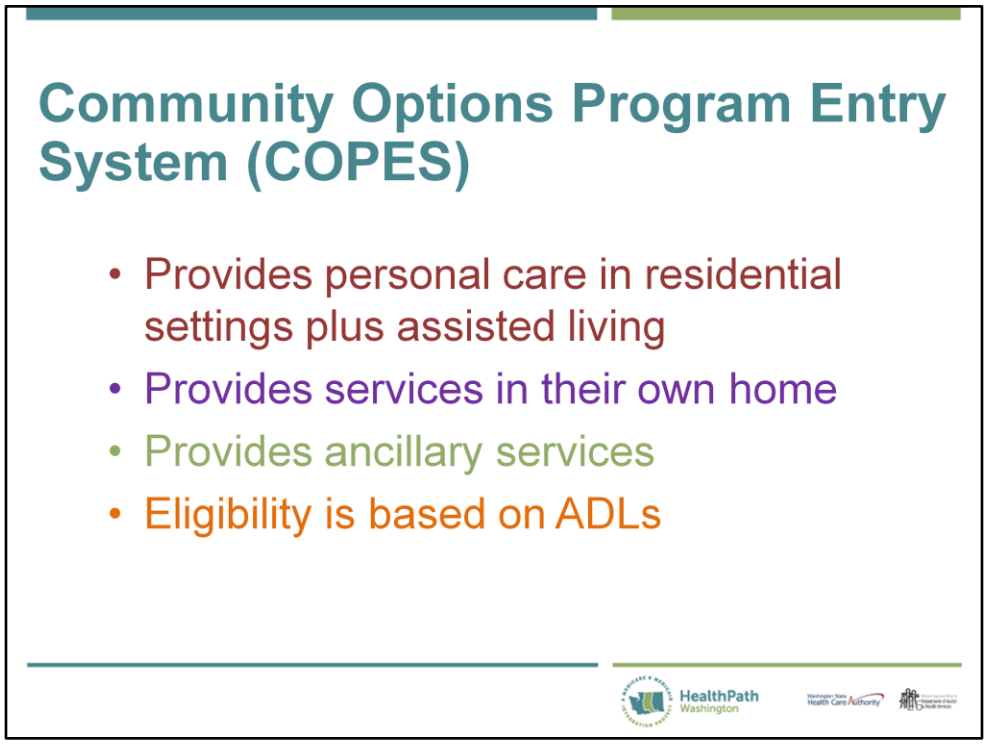
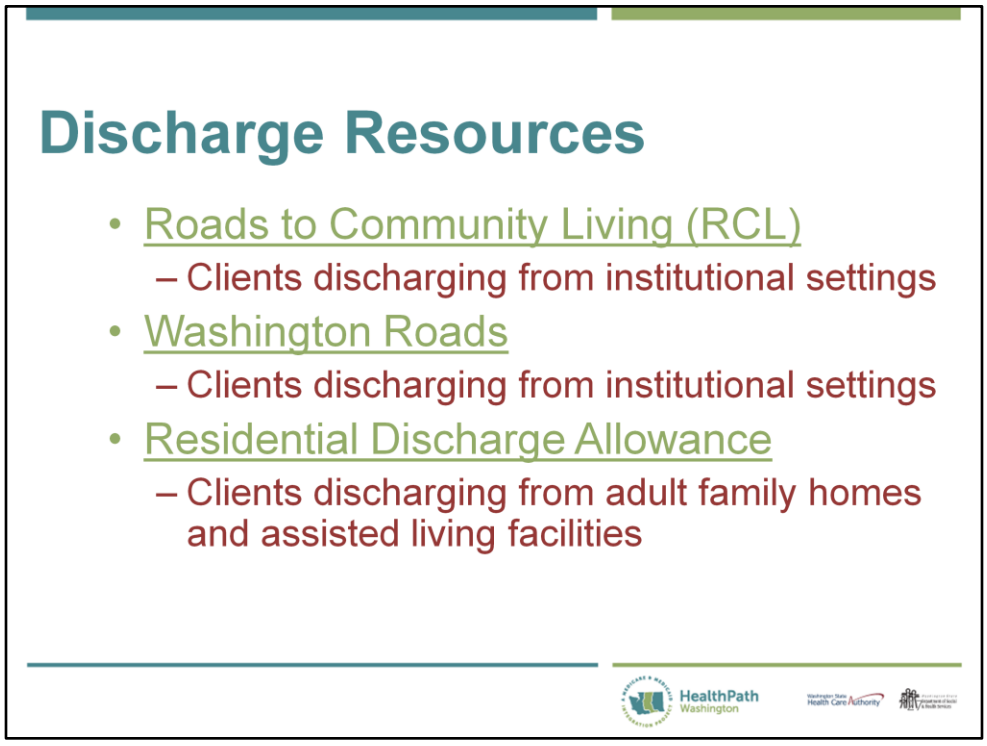
The need for assistance with IADLs alone will not qualify the client for personal care services. The client must require assistance with some ADLs.

The scoring on ADLs and IADLs effect the number of hours for in-home care or the daily rate paid for residential settings. Within CARE is an algorithm that computes the number of hours and rate.

Other factors that effect the algorithm include: moods and behaviors, clinical complexity, and support available to the client through unpaid caregivers. Unpaid caregivers may be family members, friends, legal representatives, and member from the community. The purpose of the program is not to supplant existing support systems but to augment those that are currently supporting the client.



The COPES program allows for an income standard that is higher than MPC. The functional eligibility requires the individual to be at nursing facility level of care or at risk of nursing facility placement within 30 days. Participants must require assistance with their personal care. Services available under this program include in-home services or around the clock care in residential facilities such as assisted living facilities and adult family homes.



Roads to Community Living is Washington's program for the Money Follows the Person federal grant. RCL provides services after discharge for up to one year. People of any age with a continuous, qualified stay of 3 months or longer in a qualified institutional setting (hospital, nursing home, ICF-ID); OR individuals in psychiatric hospitals with a continuous stay of 3 months or longer who are 21 and younger, or 65 and older may qualify. The assumption is that adults, ages 22 to 64 years, in psychiatric hospitals are eligible for other services so the use of the RCL program would be a duplication of services.

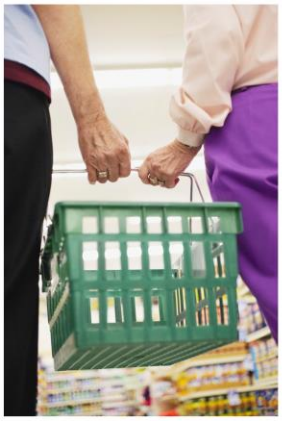
The Washington Roads Program is another discharge resource for clients who do not qualify for the Roads to Community Living. It requires that clients must be eligible for Medicaid in order to receive services that will prepare them for transition in to the community.

When a client living in an assisted living facility or adult family home is able to discharge and live in their own home in the community they may be eligible to receive funds to assist with setting up housing and furnishing their new home. Residential care case managers have access to these funds and can assist the client with this transition.

There are a number of other services that you may want to consider as options for your clients.

AAA Programs

- Family Caregiver Support Programs
- Respite Care Program
- Meal and nutritional programs
- Private and public special funds



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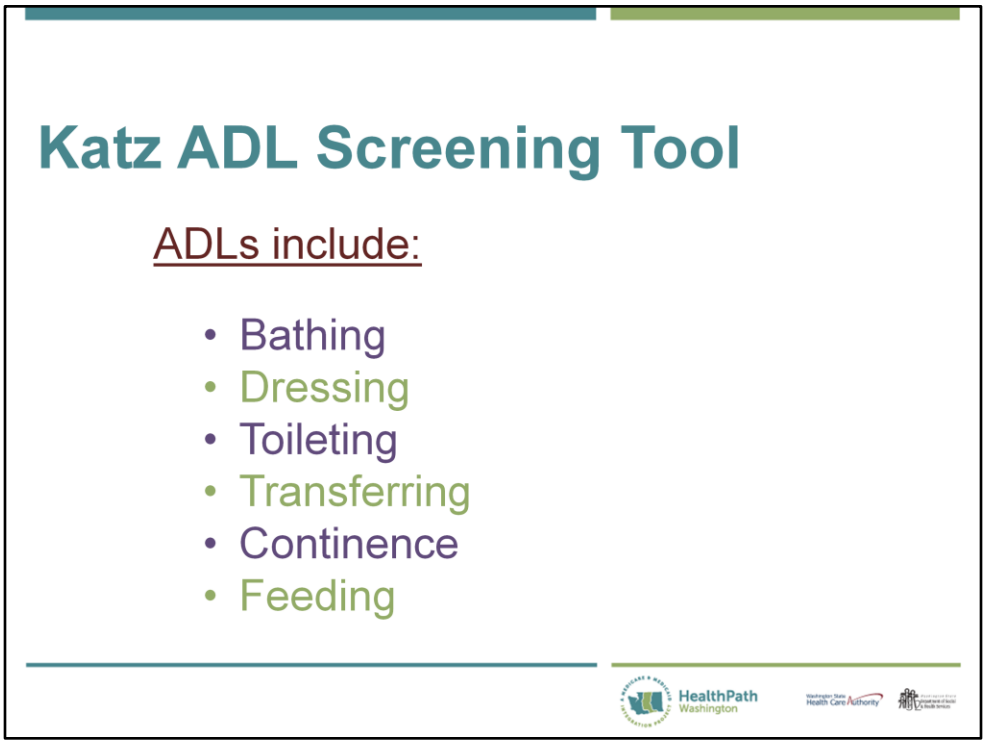
The Area Agencies on Aging have additional services that are not available through HCS and DDA which are funded through the Older Americans Act. These services may vary across agencies depending on the grants and special funds the agencies have accessed.

These are just a few of the ancillary services available to your clients who are receiving RCL or COPES services. Many of these services are not available for clients receiving MPC. Client receiving MPC, if they can meet the higher ADL needs standard, may be converted to COPES in order to take advantage of these additional benefits.

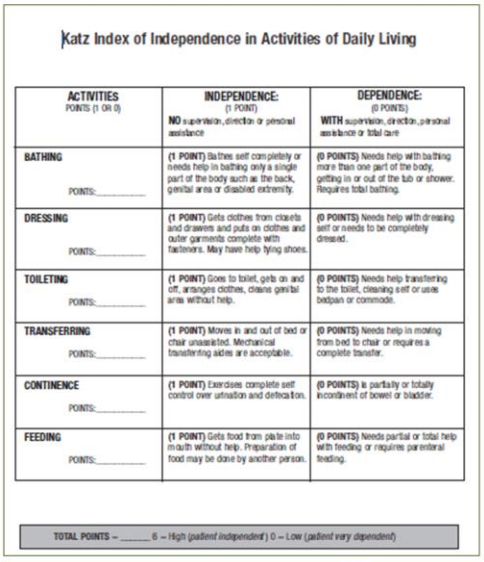
In-home and residential care services are available to clients based on their functional care needs. Functional eligibility means personal care or care of the person, not their environment.



The Katz ADL Screening Tool was presented at the Two-Day Basic Training and is contained in the Clinical Resources and Additional Assessment References manual you received at training. Completion of this assessment is required as part of the Health Action Plan (HAP) and must be administered at least every four months.

A higher score on the Katz may be a cue that the client may be considered for LTSS and that options for care should be discussed. Discussing the need for personal care assistance could result in a referral to the Area Agencies on Aging, HCS, DDA, or Children's Administration office.

Katz Index of Independence in Activities of Daily Living



Katz Index of Independence in Activities of Daily Living

ACTIVITIES POINTS (1 OR 0)	INDEPENDENCE: (1 POINT) **NO** supervision, direction or personal assistance	DEPENDENCE: (0 POINTS) **WITH** supervision, direction, personal assistance or total care
BATHING POINTS:_____	**(1 POINT)** Bathes self completely or needs help in bathing only a single part of the body such as the back, genital area or disabled extremity.	**(0 POINTS)** Needs help with bathing more than one part of the body, getting in or out of the tub or shower. Requires total bathing.
DRESSING POINTS:_____	**(1 POINT)** Gets clothes from closets and drawers and puts on clothes and outer garments complete with fasteners. May have help tying shoes.	**(0 POINTS)** Needs help with dressing self or needs to be completely dressed.
TOILETING POINTS:_____	**(1 POINT)** Goes to toilet, gets on and off, arranges clothes, cleans genital area without help.	**(0 POINTS)** Needs help transferring to the toilet, cleaning self or uses bedpan or commode.
TRANSFERRING POINTS:_____	**(1 POINT)** Moves in and out of bed or chair unassisted. Mechanical transferring aides are acceptable.	**(0 POINTS)** Needs help in moving from bed to chair or requires a complete transfer.
CONTINENCE POINTS:_____	**(1 POINT)** Exercises complete self control over urination and defecation.	**(0 POINTS)** Is partially or totally incontinent of bowel or bladder.
FEEDING POINTS:_____	**(1 POINT)** Gets food from plate into mouth without help. Preparation of food may be done by another person.	**(0 POINTS)** Needs partial or total help with feeding or requires parenteral feeding.

TOTAL POINTS = _____ 6 = High (*patient independent*) 0 = Low (*patient very dependent*)

Slightly adapted from Katz, S., Down, T.D., Cash, H.R., & Grotz, R.C. (1970) Progress in the development of the index of ADL. The Gerontologist, 10(1), 20-30.Copyright © The Gerontological Society of America. Reproduced [Adapted] by permission of the publisher. Katz Index of Independence in Activities of Daily Living: A Series Provided by The Hartford Institute for Geriatric Nursing

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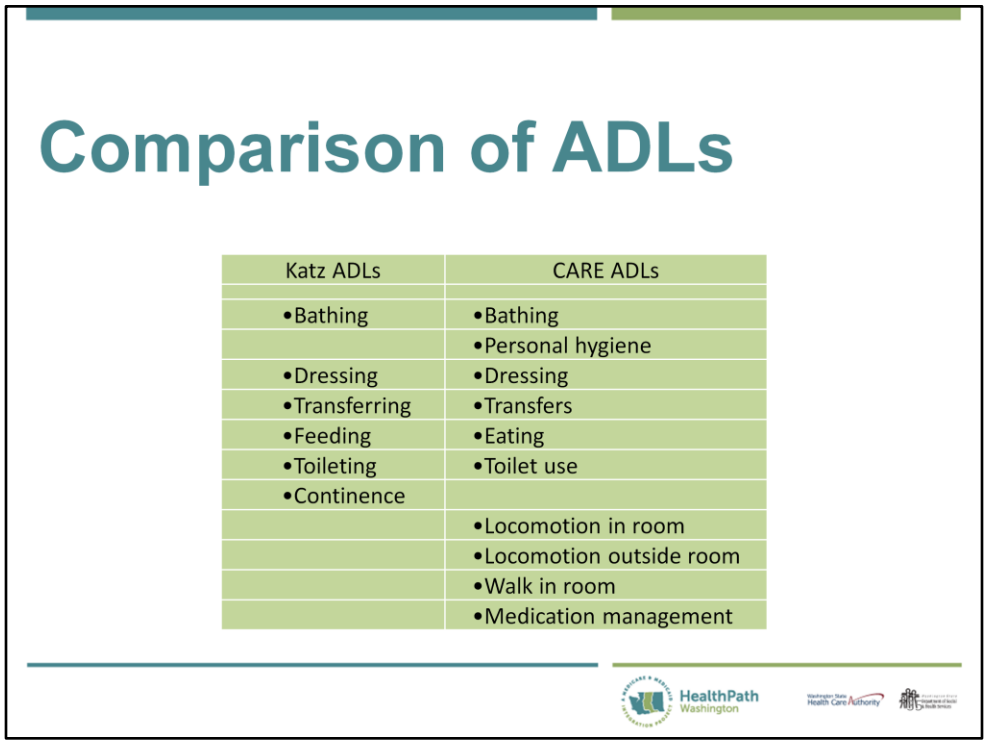
This is an image of the Katz ADL Screening Tool that was presented at the Two-Day Basic Training. While it simply indicates if a client is dependent on assistance with a particular ADL, Care Coordinators should be prepared to describe their client's capabilities and needs for assistance with specific ADLs when working with case managers.

Katz ADLs and Functional Eligibility

- The ADLs listed on the Katz align with the ADLs contained in the CARE and can assist care coordinators in determining if a client may qualify for core personal care programs with HCS, DDA, Children's Administration, and the AAAs
  - Performance of the Katz provides an opportunity to discuss functional ability and care needs which may incorporated into the HAP



Completing the Katz ADL tool may provide an opportunity to educate the client and collaterals about services that could benefit them in their own home. It can provide an opportunity to examine the various residential settings available to the client. This may include discussion about temporary nursing facility placement.

Opportunities to Partner With Case Managers

In working with clients or their collaterals consider if the client continues to meet financial standards for Medicaid. Clients must be eligible for Medicaid in order to remain in the health home program. You may need to help them maintain this eligibility. Questions to consider include:

- Have they submitted their eligibility review? Reviews are required at least annually and may be required more often if there are expected changes with their income or financial resources.
- Have they provided the requested documentation?
  - Did the client receive a letter from the financial service specialist at DSHS which indicates the documents required in order to determine their ongoing eligibility for coverage? Your assistance may be needed to help the client or ensure that the family or legal representative is pursuing this information and submitting it on the client's behalf.

In your role as a Care Coordinator you may also want to coordinate with the HCS, DDA, or AAA case manager to ensure that the needed information has been submitted.

Questions you may consider asking the client or their collaterals include:

- Has a CARE assessment been scheduled to determine initial eligibility for in-home or residential care?
- Can you assist with scheduling the assessment or educate the client on how to request an assessment through coaching and support?
- Do you need to be present during the assessment or coordinate with collaterals to attend the assessment?
- Can you help the client prepare for the assessment by ensuring that there is a complete list of current medications available for the case manager?

If the client is currently receiving LTSS services and you have identified a significant change with your client's functioning you should report these changes to the case manager. You may request a significant change CARE assessment after discussing these changes with the case manager.

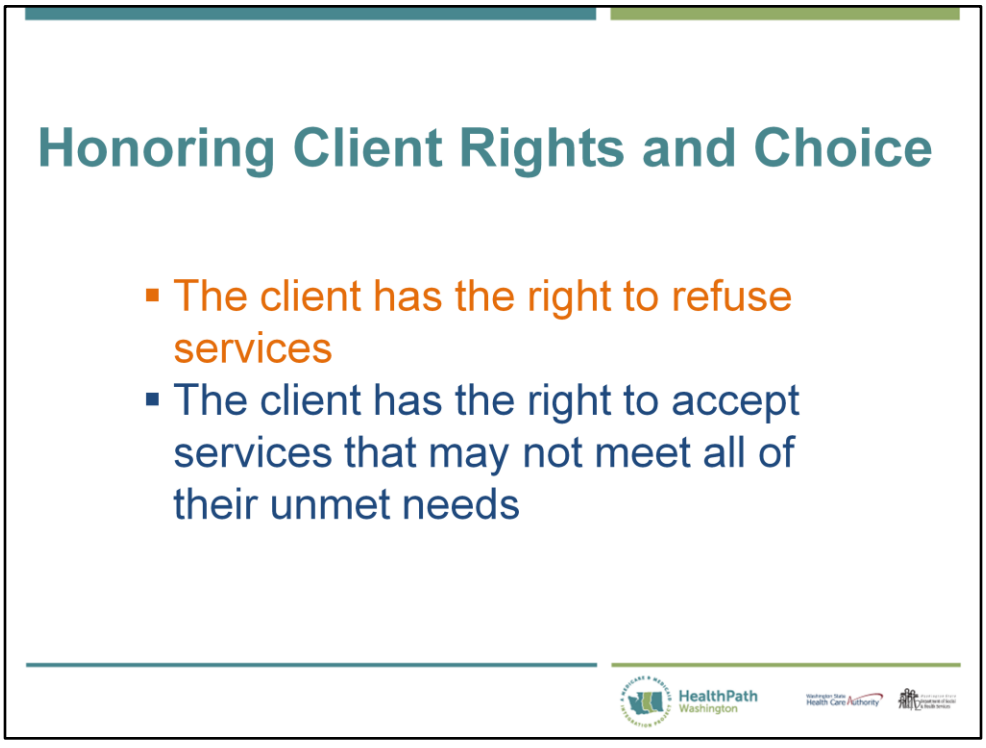
You should determine if someone should be present and if you are the appropriate person to attend the assessment visit.

Consider if the client can accurately report their care needs. Are they comfortable addressing issues with their caregiver or will they need your assistance?

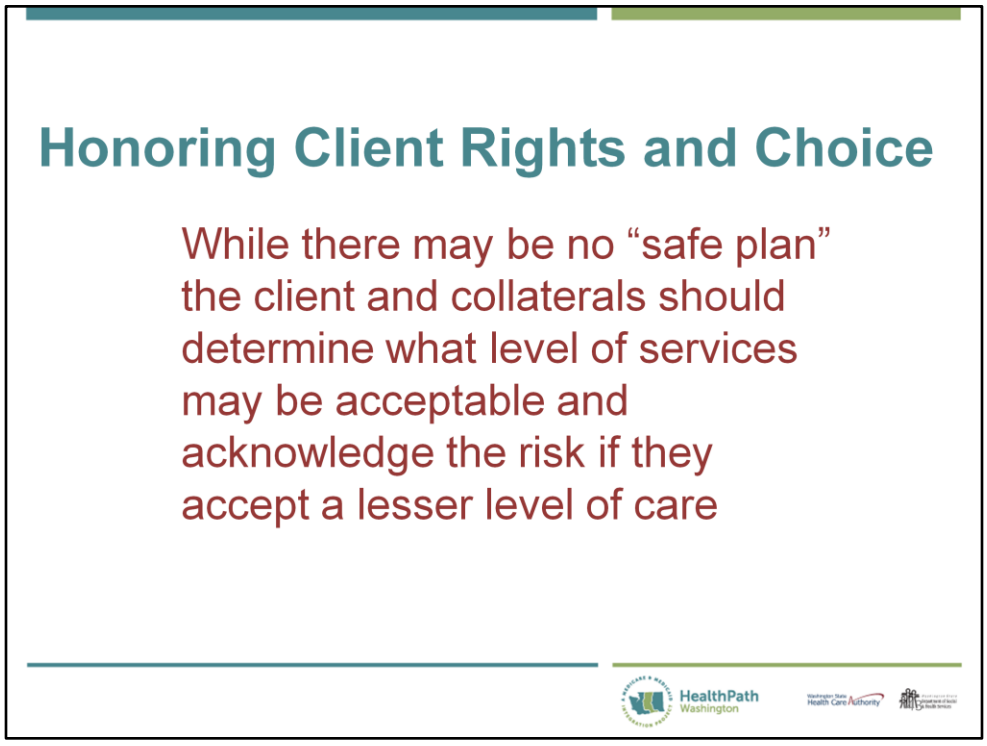
You should collaborate with the case manager to discuss medical noncompliance.
For example: can you work with the case manager to encourage the client to plan for their appointment with their personal care physician?
You should report to the case manager that the client is missing appointments.
Is there an issue with the client remembering their appointments?
Is the lack of reliable transportation to the appointment a barrier?
Does the adult family home provider need some coaching about the importance of ensuring the client is able to make their appointments?
You should work with the case manager if you identify that the caregiver is not showing up or not providing services that the client needs in order to remain independent.

For example, if a case manager is preparing a client for discharge from a hospital or nursing facility discharge by completing tasks such as ordering durable medical equipment, we do not want to supplant their work. Our role is to work with the discharge team to ensure that care transitions are occurring. Our role is to identify any gaps in the discharge plan and work with the responsible parties to ensure a safe discharge. Care Coordinators will follow the client from the facility in to the community to continue the long term coordination of their care. Care Coordinators do not duplicate the role of case managers, they provide continuity between settings and case managers.

Recall in the two-day training that we discussed care transitions as one of the six roles of care coordination. We do not want to duplicate services but ensure that the services are being planned for and provided.



Client have the right to make choices about the services they may wish to receive or refuse. At the training we talked about the need to meet the client where they are. They must determine their long and short term goals. If they do not develop these and the action steps required to meet their goals they may be less likely to participate in the Health Action Plan.



For example, if a client requires unscheduled services 24 hours a day which are not available in the in-home setting the client has the right to choose a more independent setting with the knowledge that all of their care needs may not be met.

Where to Locate Local Case Management Resources

- Developmental Disabilities Administration
  - *www1.dshs.**wa**.gov/ddd/index.shtml*
- Children's Administration
  - *www.dshs.wa.gov/ca*

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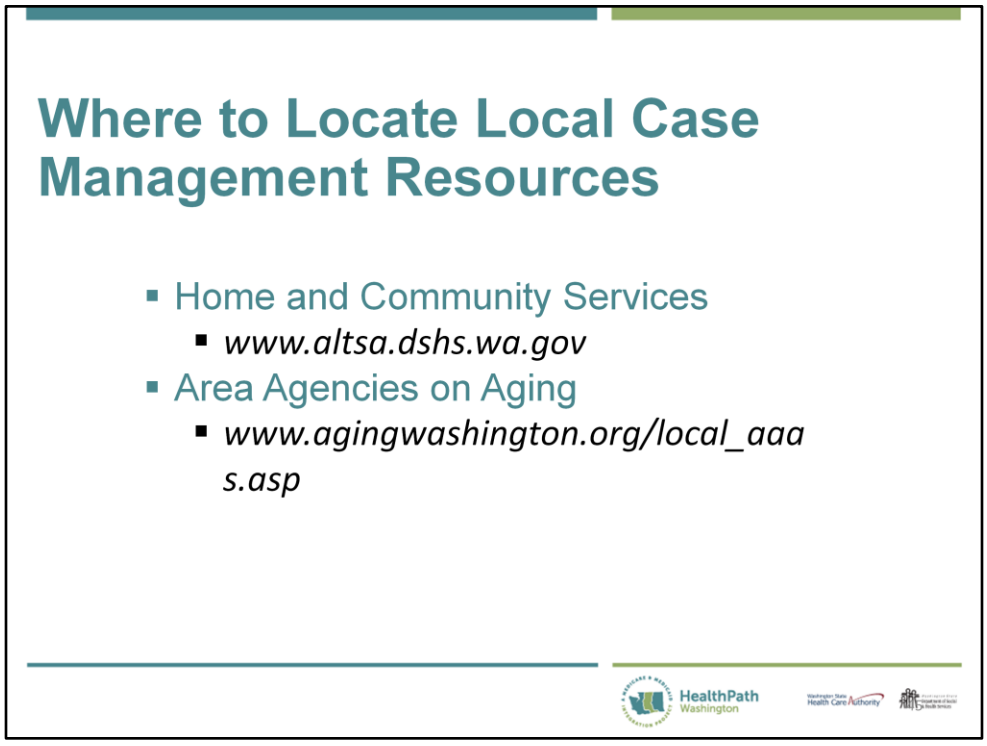
These are the links to Web sites which provide more detailed information about services available to our clients.



Here are the links to HCS and the AAAs.

Collaboration aids our mutual clients by:

- Ensuring that personal care services are adequate
- Providing the caregiver with support, education, and coaching: by either the case manager or Care Coordinator
- Increasing better utilization of behavioral and medical health care
- Increasing the chances for better health outcomes and in some cases slowing the progression of chronic conditions
- Helping to reduce health care costs by preventing avoidable readmissions to hospitals
- Preventing disjointed use of emergency departments in lieu of consistent care by primary care physicians

This is my contact information if you would like further information about LTSS.

If you were not able to attend the Webinar held on December 12, 2013 please print this slide then sign and date it after reviewing all of the slides and speaker's notes. Your supervisor should sign to verify completion of this training. Please retain a copy for your records.